BRIER CREEK VISION CARE & THE CENTER FOR VISUAL LEARNING & REHABILITATIVE THERAPY
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VISION REHABILITATION SYMPTOM CHECKLIST

Name:______________________________ Age: ______ Today's date: ______________

Please circle the number that best matches your observations.	Never	Seldom	Occasionally	Frequently	Always
Distance vision is blurry (even with glasses)	0	1	2	3	4
Near vision is blurry (even with glasses)	0	1	2	3	4
Difficulty changing focus from one distance to another	0	1	2	3	4
Eye discomfort / Eyestrain	0	1	2	3	4
Pain with movement of eyes	0	1	2	3	4
Fluorescent / artificial light is bothersome	0	1	2	3	4
Sunlight is exceptionally bothersome	0	1	2	3	4
Headaches	0	1	2	3	4
Double vision	0	1	2	3	4
Close / cover one eye to see better	0	1	2	3	4
Tilt / turn head to one side excessively	0	1	2	3	4
Fatigue quickly when reading	0	1	2	3	4
Lose place when reading	0	1	2	3	4
Words jump or move around when reading	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Difficulty with peripheral / side vision	0	1	2	3	4
Clumsy / bumps into things	0	1	2	3	4
Bothered by busy, crowded environments	0	1	2	3	4
Patterned carpets / wallpaper are bothersome	0	1	2	3	4
Motion sensitivity	0	1	2	3	4
Car sickness	0	1	2	3	4
Misjudge where objects really are	0	1	2	3	4
Awkward / poor balance	0	1	2	3	4
Dizziness	0	1	2	3	4
Prone to falls	0	1	2	3	4